TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445494	A. BUILDING _____ B. WING _____	07/31/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF RHEA COUNTY	10055 RHEA COUNTY HIGHWAY DAYTON, TN 37321

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS During the recertification survey and complaint investigation numbers 32063, 32138, conducted on July 31, 2013, at Life Care of Rhea County, no deficiencies were cited in relation to the complaints under 42 CFR PART 482.13, Requirements for Long Term Care.	F 000		
F 159 SS=C	483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section. The facility must deposit any resident's personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $50 in a non-interest bearing account, interest-bearing account, or petty cash fund. The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted	F 159	F159 What corrective action will be taken to correct this alleged deficient practice? a. Resident #92 will have access to personal trust fund. Residents with personal Trust Fund Accounts managed by the facility will have access to personal funds n the weekend beginning 8/10/13. Identify residents that have the potential to be affected by the alleged deficient practice. a. All Facility Residents who have a personal trust fund account, which is managed by the facility, has the potential to be affected What measures will be put into place or what systematic changes will you make to ensure that the deficient practice does not recur? a. All Business Office Associates were in-serviced on process of residents having access to personal trust funds on 8/8/13. b. Residents were educated during Resident Council on 8/6/13 of access to personal trust fund. Residents with personal trust funds will also be notified in writing on next billing statement. c. Business Office Manager will audit 10% of the residents with personal trust funds twice monthly for three months to determine the residents overall understanding that their account is accessible on weekends.	09/13/2013

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kate Swafford — TITLE: Executive Director — (X6) DATE: 8/9/13

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 159	Continued From page 1 accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative. The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI. This REQUIREMENT is not met as evidenced by: Based on review of personal trust fund accounts and interview, the facility failed to allow residents access to personal funds for forty-five residents with a personal trust fund account managed by the facility. The findings included: Interview with Resident #92 on July 30, 2013, at 10:04 a.m., in the resident's room revealed, "... Can't get it (money from personal trust fund account) on weekends and I hate that ..." Review of the facility personal trust fund account	F 159	How the corrective action(s) will be monitored to ensure the deficient practice will not recur and what quality assurance program will be put into place? a. The Business Office Manager or the Nursing Home Administrator will report the results to the Performance Improvement Committee: (which consists of; the Nursing Home Administrator, Medical Director, Director of Nursing, Assistant Director of Nursing/Staff Development Coordinator, Human Resource Director, Dietary Manager, Admissions/Marketing Coordinator, Business Office Manager, Housekeeping/Laundry Director, Activity Coordinator, Health Information Manager, and Maintenance Director). b. The Performance Improvement Committee will review the results of the report and ensure that all residents have been informed about the availability of fund withdrawal on weekends	

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F 159	Continued From page 2 dated July 30, 2013, revealed the facility manages personal trust fund accounts for forty five residents. Interview with the Receptionist on July 31, 2013, at 1:20 p.m., in the Business Office Manager's office confirmed residents only have access to personal funds Monday through Friday, 7:30 a.m. to 4:30 p.m.	F 159		
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, interview, and review of manufacturer's instructions, the facility failed to assess the use of bolsters as a potential restraint for one (#17) of forty -six residents reviewed. The findings included: Resident #17 was admitted to the facility on June 10, 2011, with diagnoses including Mental Disorder, Chronic Airway Obstruction, Hypertension, Tachycardia, Narcolepsy, and Intracerebral Hemorrhage. Medical record review of the Minimum Data Set (MDS) dated July 24, 2013, revealed the resident scored a '9' on the Brief Interview for Mental	F 221	F221 What corrective action will be taken to correct this alleged deficient practice? a. Resident #17 was reassessed for use of bolsters as a potential restraint. Bolsters were discontinued on 8/6/13. Identify residents that have the potential to be affected by the alleged deficient practice. a. All residents with bolsters were assessed for the use of bolsters as a potential restraint by Assistant Director of Nursing on 8/6/13. As a result, bolsters were discontinued. What measures will be put into place or what systematic changes will you make to ensure that the deficient practice does not recur? a. All Nursing Personnel will be in-serviced on physical restraint policy by Staff Development Coordinator on 8/8/13 to 8/14/13 b. Any new residents with potential for bolsters as intervention will be assessed for potential restraints by MDS Coordinator.	09/13/2013

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F 221	Continued From page 3 Status (BIMS) indicating moderately impaired cognitive ability. Review of the MDS revealed the resident required extensive assist for all activities of daily living except eating; and no restraints were in use. Medical record review of the Physician's Recapitulation Orders for July 1-31, 2013, revealed an order dated April 2, 2012, for 'Bolsters to bed'. Review of the manufacturer's instruction sheet revealed the bolsters are 34 inches long, 7 inches high, and 7 ½ inches wide. Observation and interview on July 29, 2013, at 3:46 p.m., with Certified Nursing Assistant (CNA) #7 revealed the resident requested assistance to go to the bathroom. Continued observation and interview revealed the resident scooted to the foot of the bed beyond the bolster and was assisted to a standing position. Observation of the resident on July 30 at 2:50 p.m., and July 31, 2013, at 10:15 a.m., revealed the resident asleep in the bed with the 1/4 upper side rails in the raised positions on both sides of the bed and bolsters on both sides of the bed in the center of the bed. Observation revealed both of the bolsters were secured snuggly to the bed. Interview with CNA #1 in the hallway outside the resident's room on July 31, 2013, at 12:14 p.m., revealed the resident does "scoot ...self to the foot of the bed (the area between the bottom of the bolster and the foot board) and get out.") Interview in the MDS office with the MDS Coordinator on July 31, 2013, at 1:04 p.m.,	F 221	How the corrective action(s) will be monitored to ensure the deficient practice will not recur and what quality assurance program will be put into place? a. The Director of Nursing will report any potential usage of bolsters as restraints to the Performance Improvement Committee: (which consists of, the Nursing Home Administrator, Medical Director, Director of Nursing, Assistant Director of Nursing/Staff Development Coordinator, Business Office Manager, Housekeeping/Laundry Director, Activity Coordinator, Health Information Manager, and Maintenance director) for three months. b. The Performance Committee will review the results and evaluate possible future actions concerning the usage of bolsters as restraints.	

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F 221	Continued From page 4 revealed the bolsters have been in use since the resident's last fall which was in April of 2012 (more than 15 months ago). Continued interview confirmed the bolsters do limit the resident's freedom and are a safety concern. Continued interview with the MDS Coordinator confirmed the bolsters were in place at the time the comprehensive assessment was completed and the facility failed to assess the bolsters as a potential restraint.	F 221		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on medical record review, facility policy review, and interview, the facility failed to perform a bladder assessment and provide a toileting program for one (#122) of forty six residents reviewed. The findings included: Resident #122 was admitted to the facility on January 25, 2013, with diagnoses including Aftercare for Healing Traumatic Fracture of Lower	F 315	F315 What corrective action will be taken to correct this alleged deficient practice? a. Resident #122 was discharged from facility. Identify residents that have the potential to be affected by the alleged deficient practice. a. All residents will be assessed for changes in frequency of incontinence and assessed for toileting program by Director of Nursing and the Assistant Director of Nursing on August 6, 2013 What measures will be put into place or what systematic changes will you make to ensure that the deficient practice does no recur? a. All nursing personnel will be in-serviced on Bladder Assessment Policy by Staff Development Coordinator on 8/8/13 to 8/14/13. b. Unit Coordinator will conduct audits on changes in urinary status weekly for four weeks, then monthly for two months. c. Director of Nursing will review audits for compliance for four weeks and monthly for two months.	09/13/2013

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F 315	Continued From page 5 Extremity, Congestive Heart Failure, Diabetes Mellitus, Hypertension, Hyperlipidemia, Cerebral Vascular Accident, and Wound Infection. Medical record review of the Bladder Monthly Flow Report Form for January 25, 2013, to January 31, 2013, revealed the resident had four bladder incontinent episodes. Review of the Admission Minimum Data Set (MDS) dated January 25, 2013 revealed the resident had occasional urinary incontinence, (less than seven episodes of incontinence). Resident a good candidate for individual training for contience of urine. Medical record review of the Bladder Monthly Flow Report Form for April 8, 2013, to April 14, 2013, revealed the resident had twenty three bladder incontinent episodes. Review of the quarterly MDS dated April 15, 2013 revealed the resident had frequent episodes of incontinence, (seven or more episodes of urinary incontinence, but at least one episode of continent voiding). Review of the facility policy, Guidelines for Completing the Urinary Assessments, Catheter Justification and Other Forms, revealed "...The charge nurse will complete the Assessment for Bowel and Bladder Training if the resident is incontinent to determine if the resident is a candidate for individual training or timed/scheduled toileting. Quarterly: An Assessment for Bowel and Bladder Training is	F 315	<u>How the corrective action(s) will be monitored to ensure the deficient practice will not recur and what quality assurance program will be put into place?</u> a. The Director of Nursing will report the incominence audit result to the Performance Improvements Committee: (which consists of, the Nursing Home Administrator, Medical Director, Director of Nursing, Assistant Director of Nursing/Staff Development Coordinator, Human Resource Director, Dietary Manager, Admissions/Marketing Coordinator, Business Office Manager, Housekeeping/Laundry Director, Activity Coordinator, Health Information Manager, and Maintenance Director). b. The Performance Improvement Committee will review the results. If it is deemed necessary by the committee, additional education may be provided; and the evaluation process continued for and additional 4 weeks until 100% compliance is achieved.	

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F 315	Continued From page 6 completed if the resident is incontinent..." Interview with the Director of Nursing in the conference room on July 31, 2013 at 2:26 p.m., confirmed the resident had a change in the frequency of incontinence, and the facility had not provided a toileting program.	F 315		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, interview, and review of manufacturer's instructions, the facility failed to provide an enviroment free of accident hazards by continuing to use bed bolster cushions causing the resident to exit at the foot of the bed for one (#17) of forty-six residents reviewed. The findings included: Resident #17 was admitted to the facility on June 10, 2011, with diagnoses including Mental Disorder, Chronic Airway Obstruction, Hypertension, Tachycardia, Narcolepsy, and Intracerebral Hemorrhage.	F 323	F323 What corrective action will be taken to correct this alleged deficient practice? e) Resident #17 has been assessed for use of bed bolster cushions. Bolsters were discontinued on Resident #17 on August 6, 2013 Identify residents that have the potential to be affected by the alleged deficient practice. a) All residents with bed bolster cushions were assessed for safety during supervised mobility with bolsters in place by the Assistant Director of Nursing on 8/6/13. This facility is free of bolster usage as of 8/6/13. What measures will be put into place or what systematic changes will you make to ensure that the deficient practice does not recur? a. All nursing personnel will be in-serviced on proper usage of safety devices by Staff Development Coordinator on 8/8/13 to 8/14/13. b. Any new residents with potential for bolsters as interventions will be assessed to see if they limit the residents freedom or present a safety concern by the MDS Coordinator.	09/13/2013

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F 323	Continued From page 7 Medical record review of the Minimum Data Set (MDS) dated July 24, 2013, revealed the resident scored a '9' on the Brief Interview for Mental Status (BIMS) indicating moderately impaired cognitive ability. Review of the MDS revealed the resident required extensive assist for all activities of daily living except eating; and no restraints were in use. Medical record review of the Physician's Recapitulation Orders for July 1-31, 2013, revealed an order dated April 2, 2012, for 'Bolsters to bed'. Review of the manufacturer's instruction sheet revealed the bolsters are 34 inches long, 7 inches high, and 7 ½ inches wide. Observation and interview on July 29, 2013, at 3:48 p.m. with Certified Nursing Assistant (CNA) #7, revealed the resident requested assistance to go to the bathroom. Continued observation and interview revealed the resident scooted to the foot of the bed beyond the bolster and was assisted to a standing position. Observation of the resident on July 30 at 2:50 p.m., and July 31, 2013, at 10:15 a.m., revealed the resident asleep in the bed with the 1/4 upper side rails in the raised position on both sides of the bed and the bolsters positioned in the center on both sides of the bed. Observation revealed both bolsters were secured snuggly to the bed. Interview with CNA #1 in the hallway outside the resident's room on July 31, 2013, at 12:14 p.m., revealed the resident does "scoot ...self to the foot of the bed (the area between the bottom of	F 323	How the corrective action(s) will be monitored to ensure the deficient practice will not recur and what quality assurance program will be put into place? a. The Director of Nursing will report any potential usage of bolsters to the Performance Improvement Committee: (which consists of, the Nursing Home Administrator, Medical Director, Director of Nursing, Assistant Director of Nursing/Staff Development Coordinator, Human Resource Director, Dietary Manager, Admissions/Marketing Coordinator, Business Office Manager, Housekeeping/Laundry Director, Activity Coordinator, Health Information Manager, and Maintenance Director). b) The Performance Improvement Committee will review the results. If it is deemed necessary by the committee, additional assessments may be requested for further study by the Committee.	

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F 323	Continued From page 8 the bolster and the foot board) and get out.") Interview in the MDS office with the MDS Coordinator on July 31, 2013, at 1:04 p.m., revealed the bolsters have been in use since the resident's last fall which was in April of 2012 (more than 15 months ago). Continued interview confirmed the bolsters do limit the resident's freedom and are a safety concern.	F 323		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE. Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on medical record review, facility policy review, and interview, the facility failed to assess the significant weight loss for one resident (#129) of forty-six residents reviewed. The findings included: Resident #129 was admitted to the facility on April 11, 2013, with diagnoses including Left Fracture Femur, Cerebrovascular Accident with Left Side Paralysis, Hypertension, Coronary Artery	F 325	F325 What corrective action will be taken to correct this alleged deficient practice? a. Resident #129 was discharged from facility. Identify residents that have the potential to be affected by the alleged deficient practice. a. The Director of Nursing on August 6, 2013 assessed all residents for significant weight loss. b. With any residents identified to have significant weight loss, those residents will be reviewed in the Residents at Risk Meeting weekly for appropriate interventions. What measures will be put into place or what systematic changes will you make to ensure that the deficient practice does not recur? a. Interdisciplinary team will be in-serviced on weight monitoring and significant losses process by the DON or registered dietician on 8/9/13. b. The Director of Nursing will audit weekly/monthly weights for significant weight changes/losses for three months.	09/13/2013

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F 325	Continued From page 9 Disease, Depression, and History of Edema. Medical record review of the physician orders dated April 11, 2013, included "...weigh upon admission and then q (every) day x (for) 3 days..." Medical record review of the Initial Data Collection Tool/Nursing Service with the admission date of April 11, 2013, revealed the weight of 253.6 pounds. Medical record review of the Weight History revealed the "Admit Weight" was not filled out. Further review revealed the first weight documented was dated April 17, 2013, for 246 pounds, a loss of 7.6 pounds or 2.9 percent (%) since the admission. Further review revealed no weights for the three days after the admission per the physician orders. Further review of the Weight History revealed on May 7, 2013, the weight of 236 pounds, a loss of 17.6 pounds or 6.9 % since the admission. Further review revealed on May 13, 2013, a weight of 239 pounds, a loss of 14.6 pounds or 5.8% since the admission 30 days prior. Medical record review of the Initial Nutrition Data Collection Assessment with the admission date of April 11, 2013, revealed the admission weight of 253.6 pounds, no significant weight change history, Ideal Body Weight (IBW) of 135 pounds, Body Mass Index of 39.7 (obese), no edema present, and the resident was eating an average of 75% with meals and not meeting the percent intake required to meet the estimated nutritional need. Further review revealed no additional dietary documentation after the initial assessment.	F 325	How the corrective action(s) will be monitored to ensure the deficient practice will not recur and what quality assurance program will be put into place? a. The Director of Nursing will report any significant weight losses monthly to the Performance Improvements Committee: (which consists of, the Nursing Home Administrator, Medical Director, Director of Nursing, Assistant Director of Nursing/Staff Development Coordinator, Human Resource Director, Dietary Manager, Admissions/Marketing Coordinator, Business Office Manager, Housekeeping/Laundry Director, Activity Coordinator, Health Information Manager, and Maintenance Director). b. The Performance Improvement Committee will review the results. If it is deemed necessary by the committee, the Director of Nursing will continue to monitor the programs for an additional 3 months until 100% compliance is achieved.	

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F 325	Continued From page 9 Disease, Depression, and History of Edema. Medical record review of the physician orders dated April 11, 2013, included "...weigh upon admission and then q (every) day x (for) 3 days..." Medical record review of the Initial Data Collection Tool/Nursing Service with the admission date of April 11, 2013, revealed the weight of 253.6 pounds. Medical record review of the Weight History revealed the "Admit Weight" was not filled out. Further review revealed the first weight documented was dated April 17, 2013, for 246 pounds, a loss of 7.6 pounds or 2.9 percent (%) since the admission. Further review revealed no weights for the three days after the admission per the physician orders. Further review of the Weight History revealed on May 7, 2013, the weight of 236 pounds, a loss of 17.6 pounds or 6.9 % since the admission. Further review revealed on May 13, 2013, a weight of 239 pounds, a loss of 14.6 pounds or 5.8% since the admission 30 days prior. Medical record review of the Initial Nutrition Data Collection Assessment with the admission date of April 11, 2013, revealed the admission weight of 253.6 pounds, no significant weight change history, Ideal Body Weight (IBW) of 135 pounds, Body Mass Index of 39.7 (obese), no edema present, and the resident was eating an average of 75% with meals and not meeting the percent intake required to meet the estimated nutritional need. Further review revealed no additional dietary documentation after the initial assessment.	F 325		

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LIFE CARE CENTER OF RHEA COUNTY	10055 RHEA COUNTY HIGHWAY DAYTON, TN 37321

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F 325	Continued From page 10 Medical record review of the Initial Minimum Data Set (MDS) dated April 18, 2013, revealed the weight of 246 pounds and no weight loss of 5 percent (%) or more in the last month. Review of the 30 day Prospective Payment System MDS dated May 13, 2013, revealed a weight of 239 pounds, and no weight loss. Medical record review of the care plan dated April 24, 2013, revealed the problem of "...res (resident) is at nutritional risk and for s/sx's(signs/symptoms) of dehydration due to need for mech.(mechanical) soft diet, use of daily diuretic..." Further review revealed no further documentation address the actual weight loss after the admission. Medical record review of the electronic nursing notes of the Resident at Risk (RAR) meetings revealed the following: April 12, 2013 "resident is a new admission, RD (Registered Dietitian) to follow with assessment, monitor weekly weights and monitor on RAR". On April 19, 2013, "resident weight is 246 down 2.99% related to possible lower extremity leg edema. Good po (by mouth) intake, continued plan of care and follow on RAR." On May 24, 2013, "weight stable with no significant change. discontinue from RAR." Review of the facility policy entitled "Weight Monitoring", last revised on March 1, 2013, revealed "...Weights...are obtained within 24 hours of admission...and recorded in (computer)...weight information is used for the following...for tracking prevalence of significant weight changes (gain or loss)...a designated licensed nurse reviews the weights for accuracy...Once the licensed nurse has reviewed	F 325		

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F 325	Continued From page 11 and approved the weight worksheet, the weight worksheet is given to the designated individual who will input data into (computer)..." Further review revealed "For evaluating weight changes...Weight variances are reviewed for residents with a 5% weight change in 30 days...each identified resident with a weight change has a current nutritional assessment/progress note...The Interdisciplinary Care Plan team address the issue of weight loss...The nutritional progress notes describe the changes, plan of action and progress or lack of progress..." Interview on July 30, 2013, at 4:00 p.m., with the Director of Nursing, in the conference room, confirmed no weights were obtained every day for three days after the admission as ordered by the physician. Interview with the Registered Nurse MDS Coordinator on July 31, 2013, at 8:35 a.m., in the MDS office, revealed the weights for the MDS were obtained from the Weight History data. Further interview confirmed the Weight History' failed to include the admission weight in order to accurately assess the weight changes resulting in an inaccurate PPS MDS. Interview with RD #1, on July 31, 201,. at 12:30 p.m., in the dining room, confirmed the resident had a significant weight loss (at or greater than 5% in 30 days) from the time of the admission to May 7, 2013. Further interview revealed the resident's weight loss had been identified in the weekly RAR meetings after the admission related to edema but had failed to document the weight changes in the dietary notes and the care plan.	F 325		

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F 327 F 327 SS=D	Continued From page 12 483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility policy, the facility failed to ensure routine hydration was provided for one resident (#163) of forty-six residents reviewed. The findings included: Review of the policy and procedure, Hydration and Nutrition, revised October, 2008 revealed "...fluid is available to residents at all times... and ...the hydration cart provides a means of offering beverages/snacks at 10 a.m., 2 p.m., and HS (night)...". Resident #163 was admitted to the facility on July 16, 2013, with diagnoses including Left Knee Joint Replacement, Total Knee Arthropathy, Anxiety, Panic Disorder, Depression, and Gastroesophageal Reflux Disorder (GERD). Interview with resident #163 on July 29, 2013, at 3:20 p.m., in the resident's room, revealed the facility only provides fluids if you ask for it. Observation of resident #163 on July 30, 2013, at 4:20 p.m., and on July 31, 2013, at 9:30 a.m., revealed the resident had a water pitcher and was requesting ice water	F 327 F 327	F327 What corrective action will be taken to correct this alleged deficient practice? a. Resident #163 was assessed for dehydration and affected fluids. No signs or symptoms of dehydration were noted. Water pitchers were filled every shift and PRN and hydration is offered three times a day and at resident request. Identify residents that have the potential to be affected by the alleged deficient practice. a. Water pitchers are filled every shift and PRN. Hydration is offered three times a day and at resident request. What measures will be put into place or what systematic changes will you make to ensure that the deficient practice does not recur? a. All nursing personnel were in-serviced on Hydration procedures by Staff Development Coordinator on 8/8/13 to 8/14/13. b. The Unit Coordinators and/or Charge Nurse will observe hydration pass and water pitchers three times a week for 12 weeks.	09/13/2013

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F 327	Continued From page 13 Observation on Hallways 100, 200, and 300 on July 29, 30, and 31, 2013, between 10:00 a.m. to 11:00 a.m. and 2:00 p.m. to 3:00 p.m., revealed no hydration cart was on the hallways. Interview with Certified Nursing Assistant, (CNA #4), on July 31,2013, at 12:38 p.m. on the 300 hall, confirmed the CNA did not see the hydration cart between 10:00 a.m. and 11:00 a.m. Interview with CNA #6, on July 31, 2013, at 12:43 p.m., in the 200 hall, confirmed the CNA did not see the hydration cart between 10:00 a.m. and 11:00 a.m. Interview with CNA # 5, on July 31, 2013, at 12:45 p.m., on the 100 hall, confirmed the CNA did not see the hydration cart. Interview with Licensed Practical Nurse (LPN #5) on July 31, 2013, at 1:05 p.m., in the 100 hall nursing station, confirmed when the Hydration CNA was not in the building, the cart was not brought out to the floor.	F 327	How the corrective action(s) will be monitored to ensure the deficient practice will not recur and what quality assurance program will be put into place? a. The Director of Nursing will report the results of the weekly audits to the Performance Improvement Committee.: (which consists of, the Nursing Home Administrator, Medical Director, Director of Nursing, Assistant Director of Nursing/Staff Development Coordinator, Human Resource Director, Dietary Manager, Admissions/Marketing Coordinator, Business Office Manager, Housekeeping/Laundry Director, Activity Coordinator, Health Information Manager, and Maintenance Director). b. The Performance Improvement Committee will review the results. If it is deemed necessary by the committee. Unit Coordinators and/or Charge Nurse will continue to observe until 100% compliance is achieved.	
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371		

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F 371	Continued From page 14 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to wash dishes in a sanitary manner, and failed to maintain dietary equipment in a sanitary manner. The findings included: Observation of the dish machine in operation revealed, and interview with the chef present during the observation, on July 29, 2013, at 9:20 a.m., confirmed, the dietary staff member working the dirty side of the dish machine pushed a dish rack containing dirty dishes in direct contact with the dish rack of clean dishes inside the dish machine in order to eject the clean dishes from the machine in two consecutive operations. Further observation revealed the chef instructing the dietary staff member working on the dirty side of the dish machine of the correct process to remove clean dishes prior to putting dirty dishes into the dish machine. Further observation revealed the dietary staff member working the dirty side of the dish machine push a rack containing dirty dishes in direct contact with the rack of clean dishes inside the dish machine in order to eject the clean dishes from the machine for the third time. Interview with the dietary staff member working the dirty side of the dish machine on July 29, 2013, at 9:20 a.m., revealed the dietary staff member pushed the dirty dishes into the clean dishes because "...(dietary staff member working clean side of dish machine) wasn't in here to remove it (clean rack inside machine)..." Observation of the dish machine in operation, on	F 371	F371 What corrective action will be taken to correct this alleged deficient practice? a) All items were cleaned and stored properly by Certified Dietary Manager and Registered Dietician on July 30, 2013. Identify residents that have the potential to be affected by the alleged deficient practice. a) All Dietary staff will be in-serviced on proper sanitation in dish washing and maintaining dietary equipment by the Dietary Manager on August 8, 2013. What measures will be put into place or what systematic changes will you make to ensure that the deficient practice does not recur? a. The dietary aide were in-serviced on proper sanitation in dish washing in the dish machine. The plate warmer is stored properly. The stand mixer has been cleaned. The flour and sugar bin lids have been cleaned. The ice machine has been cleaned. The grill and spill pans have been cleaned. The microwave has been cleaned. b. The Dietary Manager will audit proper sanitation in dish washing and cleanliness of dietary equipment three times weekly for twelve weeks.	09/13/2013

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F 371	Continued From page 15 July 30, 2013, at 9:19 a.m., revealed, and interview with the Certified Dietary Manager from a sister facility present during the observation, confirmed the dietary staff member (same dietary member as observation on July 29, 2013, at 9:20 a.m.) working the dirty side of the dish machine push a dish rack containing dirty dishes in direct contact with the dish rack of clean dishes inside the dish machine in order to eject the clean dishes from the machine. Observation on July 30, 2013, beginning at 9:19 a.m., revealed, and interview with the Certified Dietary Manager from a sister facility present during the observation, confirmed the following: 1.) The plate warmer was stored in direct contact of the dry goods store room floor. 2.) The stand mixer across from the walk-in refrigerator had dried debris on the underside of the beater arm, had an accumulation of dried debris inside the mixer bowl, and had sticky debris surrounding the suction cushions attached to the legs of the mixer. 3.) The flour and sugar bin lids had dried debris present. 4.) The can opener on the preparation table had sticky debris on the blade and in the slot of the base. 5.) The right side of the interior of the ice machine had black colored spots. 6.) The corners of the grill had an accumulation of blackened debris. 7.) The grill spill pan was full of dark colored liquid and debris. 8.) The interior of the microwave had dried splattered debris present.	F 371	How the corrective action(s) will be monitored to ensure the deficient practice will not recur and what quality assurance program will be put into place? a. The Nursing Home Administrator will review audits weekly for compliance and report monthly to the Performance Improvements Committee: (which consists of the , Nursing Home Administrator, Medical Director, Director of Nursing, Assistant Director of Nursing/Staff Development Coordinator, Human Resource Director, Dietary Manager, Admissions/Marketing Coordinator, Business Office Manager, Housekeeping/Laundry Director, Activity Coordinator, Health Information Manager, and Maintenance Director). b. The Performance Improvement Committee will review the results. If it is deemed necessary by the committee, the documentation and auditing will continue for an additional twelve weeks until 100% compliance is achieved.	
F 372 SS=D	483.35(f)(3) DISPOSE GARBAGE & REFUSE PROPERLY	F 372	F372 What corrective action will be taken to correct this alleged deficient practice? a. The Dumpster area was cleared of garbage and debris by the Housekeeping Director on July 31, 2013. Identify residents that have the potential to be affected by the alleged deficient practice. a) All associates responsible for disposal of garbage will be in-serviced on proper disposal of garbage by Housekeeping Director on Aug 8 and Aug 12, 2013.	09/13/2013

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F 372	Continued From page 16 The facility must dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to dispose of garbage properly. The findings included: Observation of the facility dumpster area revealed, and interview with the chef, present during the observation, confirmed on July 29, 2013, beginning at 9:20 a.m., two full plastic bags and two plastic gloves were on the concrete pad outside of the dumpster. Further observation revealed one of the full plastic bags was under the dumpster leg. Further interview revealed on "...Friday the ground was covered with plastic bags because they (garbage service provider) hadn't picked up yet..." Observation of the facility dumpster area revealed, and interview with the Certified Dietary Manager from a sister facility, present during the observation, confirmed on July 30, 2013, at 9:55 a.m., the remnants of a plastic bag with debris was under the leg of the dumpster.	F 372	What measures will be put into place or what systematic changes will you make to ensure that the deficient practice does not recur? a. The Housekeeping Director will observe Dumpster area for proper disposal of garbage three times a week for twelve weeks starting Aug 12, 2013. How the corrective action(s) will be monitored to ensure the deficient practice will not recur and what quality assurance program will be put into place? a. The Housekeeping Director will report results of audits on proper disposal of garbage to the will report the Performance Improvements Committee: (which consists of; the Nursing Home Administrator, Medical Director, Director of Nursing, Assistant Director of Nursing/Staff Development Coordinator, Human Resource Director, Dietary Manager, Admissions/Marketing Coordinator, Business Office Manager, Housekeeping/Laundry Director, Activity Coordinator, Health Information Manager, and Maintenance Director). b. The Performance Improvement Committee will review the results. If it is deemed necessary by the committee, the documentation and auditing will continue for an additional twelve weeks until 100% compliance is achieved	
F 431 SS=F	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug	F 431		

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F 431	Continued From page 17 records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to appropriately store internal and external medications and preparations for three of three medication carts observed. The findings included: Observation of the 100 hall medication cart on	F 431	F431 What corrective action will be taken to correct this alleged deficient practice? a. The containers were removed from each medication cart and items stored correctly by Unit Coordinators on 7/31/13. b. Licensed personnel were in-serviced by Staff Development Coordinator on 8/8/13 to 8/14/13 for proper storage procedures on internal and external medications and preparations. Identify residents that have the potential to be affected by the alleged deficient practice. a. All medication carts were checked for proper storage of internal and external medications by Unit Coordinators on 7/31/13. What measures will be put into place or what systematic changes will you make to ensure that the deficient practice does not recur? a. All licensed personnel were in-serviced on proper storage of internal and external medication on 8/8/13 to 8/14/13 by Staff Development Coordinator. b. Medication carts will be audited weekly for four weeks, and then monthly for two months by the Director of Nursing and Staff Development Coordinator for compliance. c. The Director of Nursing or Nursing Home Administrator will review the medication carts and audits starting on 8/12/13 to 9/9/13 and then monthly for two months.	09/13/2013

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F 431	Continued From page 18 July 31, 2013, at 9:35 a.m., with Licensed Practical Nurse (LPN #2) in the 100 medication room revealed a basket in the right top drawer containing five Bisacodyl suppositories, five Lidocaine 5% ampules, along with nail clippers and alcohol wipes. LPN #2 confirmed the two medications were not stored properly. Observation of the 200 hall medication cart on July 31, 2013, at 9:55 a.m., with LPN # 4 in the 200 medication room revealed a basket in the right top drawer containing four Bisacodyl suppositories, two AAA batteries, and an Accudose machine. LPN #4 confirmed the medication were not stored properly. Observation of the 300 hall medication cart on July 31, 2013, at 12:55 p.m., with LPN #3 in the 300 hall revealed a basket in the right top drawer containing three single use packets of A&D ointment and two vials of single use Normal Saline solution. LPN #3 confirmed the medication was not stored properly.	F 431	How the corrective action(s) will be monitored to ensure the deficient practice will not recur and what quality assurance program will be put into place? a. The Director of Nursing or the Nursing Home Administrator will report the results of the medication cart audit to the Performance Improvement Committee: (which consists of, the Nursing Home Administrator, Medical Director, Director of Nursing, Assistant Director of Nursing/Staff Development Coordinator, Business Office Manager, Housekeeping/Laundry Director, Activity Coordinator, Health Information Manager, and Maintenance Director). b. The Performance Improvement Committee will review the results. If it is deemed necessary by the committee, additional education may be provided; the process evaluated/revised and/or the audits continued, for three months until 100% compliance is achieved.	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation,	F 441		

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F 441	Continued From page 19 should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and facility policy review, the facility failed to provide sanitary conditions for two residents (#122 and #219) of forty-six residents reviewed. The findings included: Observation during medication administration review on the 200/300 hallway on July 30, 2013, at 8:00 a.m., revealed Licensed Practical Nurse (LPN) #3 failed to remove gloves and wash hands before giving a subcutaneous injection to	F 441	F441 What corrective action will be taken to correct this alleged deficient practice? a) Licensed Practical Nurse #3 was educated by Director of Nursing and Staff Development Coordinator on infection control in relation to proper hand washing and usage of gloves and cleaning of equipment, to include blood pressure cuff and oximeter, used on residents by Staff Development Coordinator on 8/17/13. Resident #219 has no signs and symptoms of infection related to injection or use of medical equipment. Licensed Practical Nurse #2 was educated by Director of Nursing and Staff Development Coordinator on infection control in relation to cleaning of medical equipment. b) All Clinical Personnel will be in-serviced on infection control in relation to proper hand washing and usage of gloves during injection of resident and all Clinical Personnel will be in-serviced on cleaning of medical equipment to include blood pressure cuff and oximeter by Staff Development Coordinator on 8/8/13 to 8/14/13 Identify residents that have the potential to be affected by the alleged deficient practice. a) All residents receiving injections were reviewed for signs and symptoms of infection, and no residents were found to be affected. No residents whose 02 Stats and BPS were obtained were found to be affected on 8/7/13. All Clinical staff was in-serviced by Staff Development Coordinator.	09/13/2013

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F 441	Continued From page 20 resident #219. Observation upon entering the room to give the medications, LPN #3 washed the hands and donned gloves. LPN #3 then proceeded to rearrange a wheelchair, a bedside commode and raised the head of the bed of the resident. Continued observation revealed LPN #3 then placed the pulse oximeter, attached to the rolling blood pressure monitoring machine, on the finger of the resident. Further observation revealed the resident then received the PO (by mouth) medication. LPN #3 then lowered the head of the bed and proceeded to give the subcutaneous injection in the abdomen. LPN #3 did not remove the gloves, wash the hands and don new gloves before giving the injection. Interview with LPN #3 at the time of the observation, confirmed did not remove gloves, wash the hands or sanitize the pulse oximeter. Observation on July 31, 2013, at 8:15 a.m., in the 100 hallway at the medication cart during medication administration review, LPN #2 entered resident #122 room with the medications and the rolling blood pressure monitoring machine. Continued observation revealed LPN #2 took the resident's blood pressure before medication administration, gave the medications and left the room with the rolling blood pressure monitoring machine. The blood pressure cuff was not sanitized before or after resident use. Interview with LPN #2 at that time confirmed she	F 441	What measures will be put into place or what systematic changes will you make to ensure that the deficient practice does not recur? a. All Nursing personnel will be in-serviced on infection control in relation to proper hand washing and usage of gloves during injection and cleaning of equipment, to include blood pressure cuff and oximeter, used on residents by Staff Development Coordinator on 8/8/13 to 8/14/13 b. Director of Nursing will conduct visual audits starting 8/12/13 to 9/9/13 and then Monthly for two months on proper hand washing and cleaning of equipment used on residents. c. Nursing Home Administrator will audit the infection control process Weekly reviews for compliance for four weeks and monthly for two months.	

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LIFE CARE CENTER OF RHEA COUNTY	10055 RHEA COUNTY HIGHWAY DAYTON, TN 37321

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 21 did not sanitize the machine or the blood pressure cuff and that the cuff is used for each resident that needs it and is not cleaned in between residents. Facility policy review of the "Subcutaneous Injection" policy revealed "...General Infection Control Guidelines:...2. Wash your hands before and after all procedures...7. Thoroughly clean all equipment used..." Facility policy review of the "Cleaning/Sanitizing, Disinfection, & Sterilization" policy revealed "...clean supplies and equipment immediately after use..." Interview with the Director of Nursing on July 31, 2013, at 2:45 p.m., in the conference room confirmed the equipment such as pulse oximeters "should be cleaned between residents."	F 441	How the corrective action(s) will be monitored to ensure the deficient practice will not recur and what quality assurance program will be put into place? 1. The Director of Nursing or the Nursing Home Administrator will report the infection audit results to the performance improvement committee: (which consists of, the Nursing Home Administrator, Medical Director, Director of Nursing, Assistant Director of Nursing/Staff Development Coordinator, Human Resource Director, Dietary Manager, Admissions/Marketing Coordinator, Business Office Manager, Housekeeping/Laundry Director, Activity Coordinator, Health Information Manager, and Maintenance Director. 2. The Performance Improvement Committee will review the results. If it is deemed necessary by the committee, additional education may be provided; the process evaluated/revised and/or the audits revived, for three months or, until 100% compliance is achieved.	
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.	F 514	F514 What corrective action will be taken to correct this alleged deficient practice? a. Resident #40 pain assessment was reviewed and updated on August 6, 2013 by Unit Coordinator. Identify residents that have the potential to be affected by the alleged deficient practice. a. All residents receiving PRN pain medications were assessed for effectiveness of medication by unit coordinators on August 13, 2013.	09/13/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445494	A. BUILDING _____ B. WING _____	07/31/2013

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F 514	Continued From page 22 This REQUIREMENT is not met as evidenced by: Based on medical record review, facility policy review, and interview, the facility failed to maintain an accurate clinical record for one resident (#40) of forty-six residents reviewed. The findings included: Resident #40 was admitted to the facility on July 1, 2009, with diagnoses including Osteoarthritis, Anxiety, Parkinson's Disease, Tachycardia, Arthritis, Peripheral Neuropathy, and Spasticity. Review of the July 2013 Recapitulation Orders revealed pain medication including Ibuprophen 200 milligrams (mg) by mouth every (po q) 12 (hours) as needed (prn) for severe pain, and Acetaminophen 500 mg po q 4 hours prn. Medical record review of the July 2013 Medication Administration Record (MAR) revealed the Acetaminophen had been administered on July 12, 15, and 20, 2013. Further review of the back of the MAR revealed no documentation of the effectiveness of the medication. Medical record review of the undated Pain Flow Sheet located in the July 2013 MAR book revealed no documentation addressing the effectiveness of the pain medication. Review of the facility policy entitled "Pain Management Protocol" with the revision date of March 2007, revealed "Procedure...4. Nursing staff will...document the effectiveness of the pain management program in the resident medical	F 514	What measures will be put into place or what systematic changes will you make to ensure that the deficient practice does not recur? a. All licensed nursing personnel will be in-serviced on Pain Medication Protocol and documentation by Staff Development Coordinator on 8/8/13 to 8/14/13. b. Unit Coordinator will audit the documentation on PRN medication three times weekly for twelve weeks. How the corrective action(s) will be monitored to ensure the deficient practice will not recur and what quality assurance program will be put into place? a. The Director of Nursing will report the audit of documentation on PRN medication results to results to the Performance Improvement Committee: (which consists of, the Nursing Home Administrator, Medical Director, Director of Nursing, Assistant Director of Nursing/Staff Development Coordinator, Human Resource Director, Dietary Manager, Admissions/Marketing Coordinator, Business Office Manager, Housekeeping/Laundry Director, Activity Coordinator, Health Information Manager, and Maintenance Director). b. The Performance Improvement Committee will review the results. If it is deemed necessary by the committee, the documentation and auditing will continue for an additional twelve weeks until 100% compliance is achieved.	

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F 514	Continued From page 23 record (Nurses' Notes/Pain Management Flow Sheet/ Medication Administration Record)..." Interview, on July 31, 2013, at 1:09 p.m., in the conference room, with the Director of Nursing, revealed the pain medication effectiveness was to be documented on the Pain Flow Sheet. Further interview confirmed the facility failed to follow the policy to document the pain medication effectiveness and the medical record was inaccurate.	F 514		